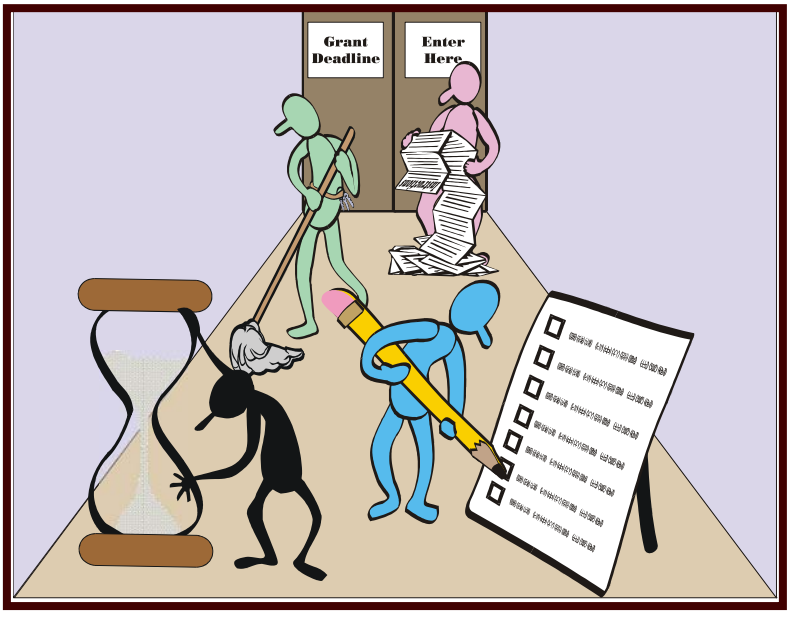
Supplemental Information and Tools
for RFP Package 2005B

for use in developing a DD Council grant proposal from RFP 2005B



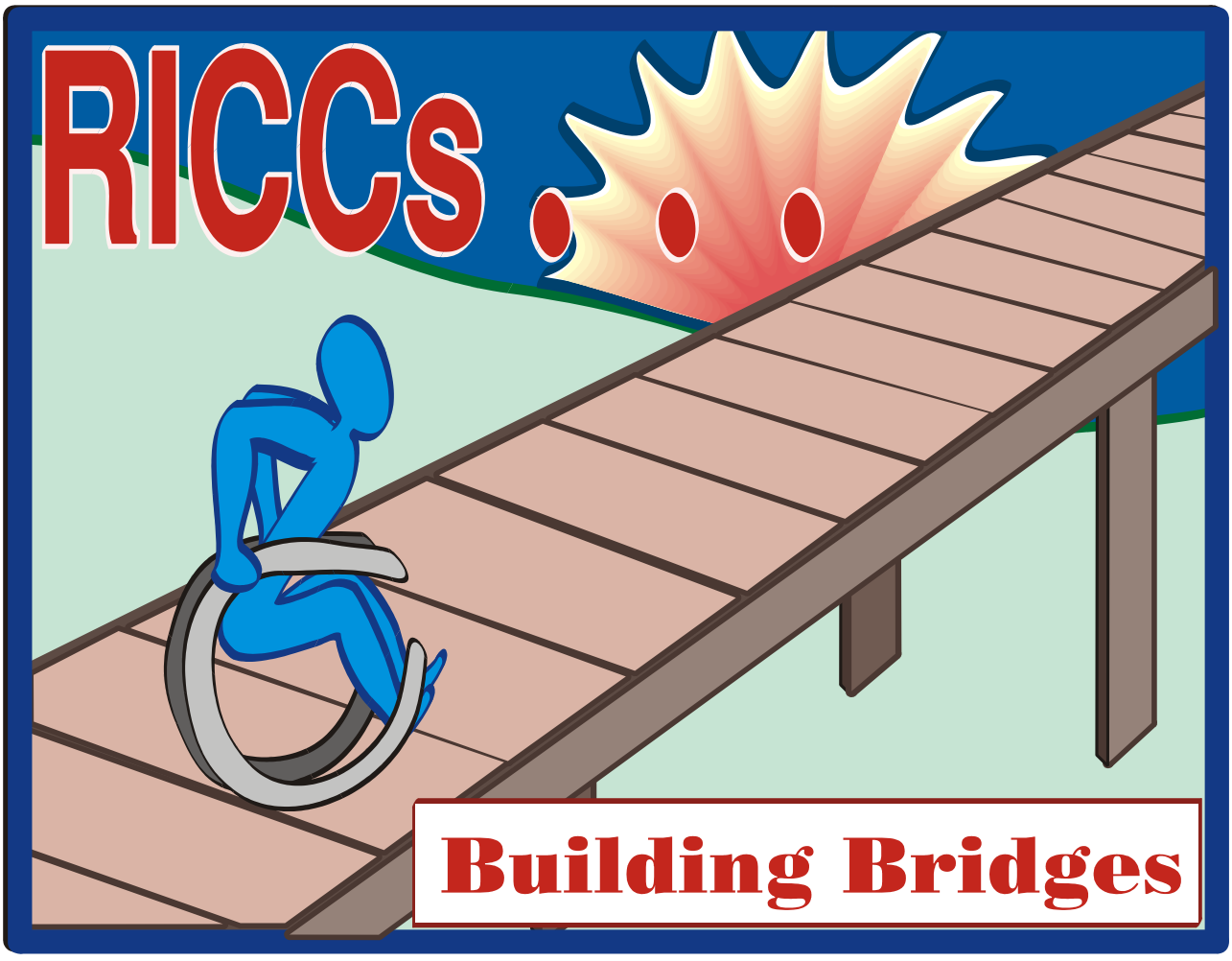
1. RICCs (Regional Interagency Coordinating Committees)

A. What Are RICCs?

B. 2005 RICC List

C. RICC Acknowledgment of Notification Form

D. RICC Review Sheet for DD Council Grant Proposals for Local Projects



1.A. What Are RICCs?

RICCs are local groups supported by the Michigan Developmental Disabilities Council. They serve as local forums about their areas' issues for people with developmental disabilities (DD). They also give the DD Council input on local needs. At least 51% of a RICC's members are people with DD or family members. RICCs have no paid staff.

The Council requires that proposals for **local** projects be submitted to the RICC in the area where the project would operate. (The RICC review requirement does not apply to proposals for state-level projects.) If you can't find the RICC for your area, call the Council office at (517) 334-6123. A few areas do not have RICCs. If your proposed project will not serve any area that has a RICC, the RICC review requirement will be waived.

Applicants for local grants must:

- **Notify their RICC** of their intention to submit a grant proposal about two weeks before the proposal deadline. (The exact date is in Section I of the RFP.) This is the only way the RICCs can know that they need to organize a review process. When you notify the RICC of your intent, you need to:
  - **Get the signature** of the chair or designee on the "RICC Acknowledgment of Notification." (It's in this package, item 1.C., following the RICC list.)
  - **Put the signed form** on top of the proposals submitted to the Council office, so that Council staff can see that you have met this requirement.
  - **Get five (5) copies** of the final proposal to the RICC. The deadline for doing this is the same as the deadline for getting them to the DD Council.

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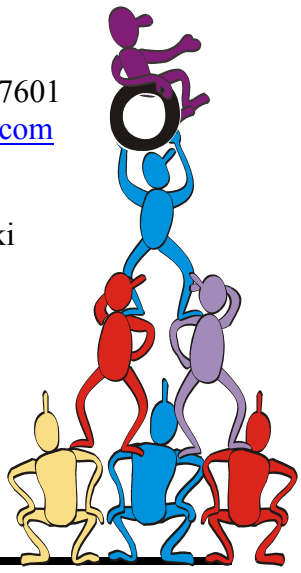

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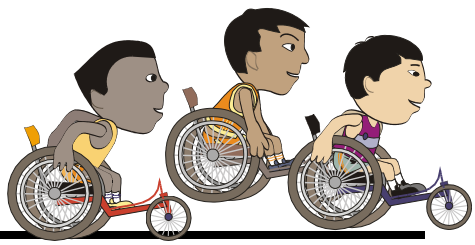

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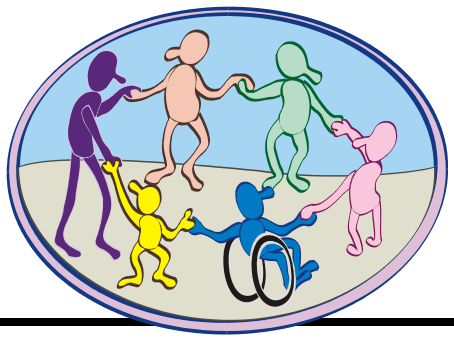

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1.B. 2005 Regional Interagency Coordinating Committees (RICCs)

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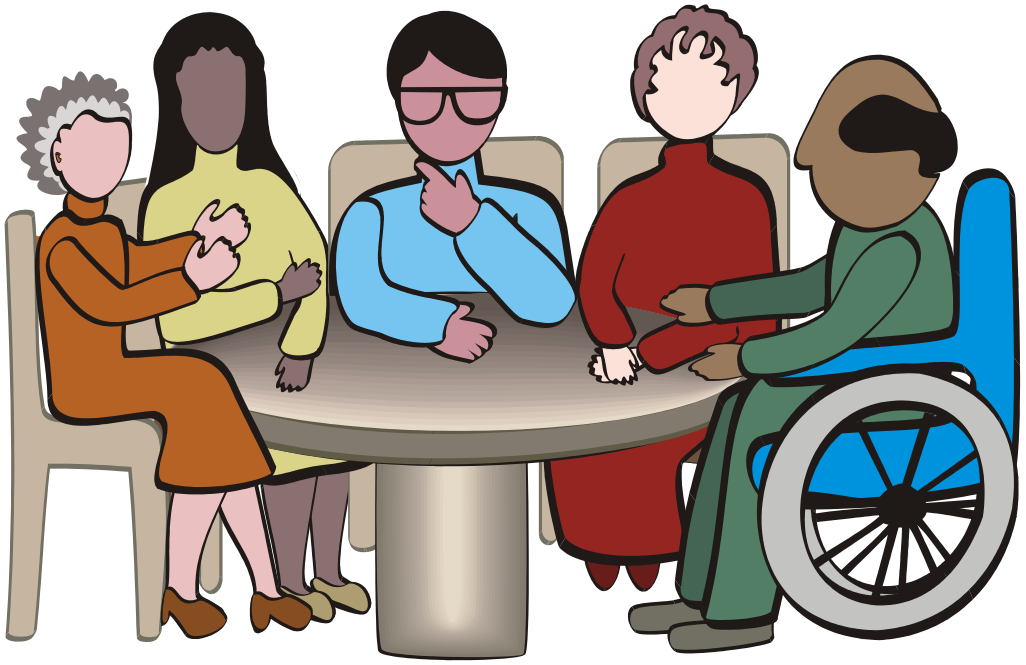


1.C. RICC Acknowledgment of Notification

Proposals for new DD Council grant funding for **local** projects, developed in response to a DD Council Request for Proposal (RFP), require review by the local RICC (Regional Interagency Coordinating Committee). RICC contact information is Item 1.B. in *Supplemental Information and Tools,* above, immediately before this form.

Grant proposals that do **NOT** require RICC notification are those that are:

- **Statewide** in scope (Statewide projects are identified under "RICC Review" in Section I of the RFP); or
- For continuation funding for an existing DD Council grant project.

Applicants must:

1. Notify their local RICC, in advance, by the date specified in Section I of the RFP (usually about two weeks before the deadline for submitting the proposal), of their intent to submit a proposal;
2. Include the RICC's signed acknowledgement of notification with the proposal submitted to the DD Council; and
3. Submit five (5) copies of the proposal to the RICC. The due date for getting the completed proposals to the RICC is the **same date** as that for getting fifteen (15) copies to the DD Council. See the RFP package for the specific date.

_____
(Applicant Organization)

has notified the _____ RICC
(RICC name)

Of their intent to submit a proposal in response to the Michigan Developmental Disabilities Council's RFP for:

_____
(Name of specific RFP)

Signed: _____
(Signature of RICC chair or designee) (Date)

This form is required ONLY for proposals for LOCAL projects developed in response to a DD Council RFP.

1.D. RICC Review Sheet **For DD Council Grant Proposals for local projects**

Signature: _____ Date: _____
(RICC Chair or Designee)

Applicant _____ Project Title _____

Reviewers: **RFP:** _____

Criteria	**Ratings**				
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. The organization has capacity to carry out the plan described by the proposal.					
2. This organization is committed and experienced in supporting self-determination for people with DD.					
3. The organization works well with other area organizations concerned about people with DD.					
4. This proposal plans activities that are needed locally, and does not duplicate existing programs.					
5. The project will enhance existing programs efficiently.					
6. The project addresses a high priority problem in this region.					
7. The organization has access to the identified target group, and their numbers are reasonable.					
8. The proposal offers a clear and practical approach to the problem.					
9. The budget reflects reasonable costs compared to other similar programs in this region.					

If this proposal is funded, how does the RICC plan to interact with the project?

Comments

2. About DD Council Grants …

Understanding why the Michigan Developmental Disabilities Council (DD Council) makes grants and how it administers RFPs, can help you decide whether to respond to a DD Council RFP. It may also improve your chances of writing a winning proposal.

Plan and RFP Process: The DD Council awards grants **only** to carry out strategies in its *Five-Year Strategic Plan*. Its competitive request for proposal (RFP) process is designed to bring in the proposals and select the projects that are most likely to achieve its targeted outcomes.

The DD Council does not encourage unsolicited proposals

and cannot assure review or consideration for proposals developed outside its planning and request for proposals process.

Values: The DD Council is a systems advocate. Its grants program is one of its tools for changing the way systems support people with developmental disabilities. The Council's objectives are increased support for:

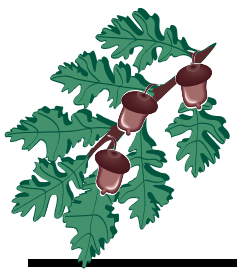
- **Self-determination** and • **Community inclusion and participation** for people with disabilities, including those in minority and culturally distinct populations.

  DD Council grants support **only** projects to make these values the reality for people with disabilities and their families. Grant projects must work in accord with these principles and may not operate in segregated "disability-only" settings.

Methods: The Council's methods stress:

- **Collaboration:** Many DD Council projects require collaboration and/or coalition. Individuals, groups or agencies working in isolation rarely accomplish systems change. Collaboration is always an asset to a grant proposal.
- **Consumer Participation:** All DD Council projects must assure participation by people with DD and their families, including those in minority and culturally distinct populations, in developing, operating and evaluating the project. Every grant proposal must describe how people with disabilities and their families participated in developing the proposal and specify their role in doing and evaluating it.
- **Outreach and cultural sensitivity**. Every grant proposal must include a plan for outreach to minority populations and plans for assuring cultural competence in doing and evaluating the project.

Outcomes and Sustainability: The Council has a small budget to influence a complex system. Proposals must show how the project would get the desired results and how improvements would be sustained beyond the grant period.



- DD Council projects must evaluate their activities and accomplishments. Proposals must show how the project would achieve the targeted outcomes, and how it would measure and document its achievements.
- Proposals must describe how capacity developed under the grant will continue and how other improvements will be sustained after the end of the grant.

Process for Reviewing Proposals and Awarding Grants:

U **Check ALL** copies of your proposal. Reviewers have difficulty understanding, or recommending, proposals with missing or out-of-order pages.

The DD Council uses a multi-level review process to select, as objectively as possible, the proposals best suited to supporting its goals. It includes:

- **(Optional) Technical assistance and review of drafts:** DD Council staff is available during regular business hours, as time allows, to answer questions, discuss project concepts, and review draft materials. To assure a thorough review, (with response in time for you to use any suggestions) get your draft in well ahead of the RFP deadline.

- **Pre-Review Screening.** A proposal goes to the full review process only if it arrives at the Council office **by the RFP deadline**, with:
  - o A complete original proposal, appropriately signed, and 15 complete copies, including:
  - o **All** the elements specified in the instructions and the RFP, with each clearly labeled, and:
  - o In readable type and format, *without* complex bindings that can't be removed one-handed.

- **The Review Group** is made up of volunteers, all of whom bring commitment to the Council's mission and broad expertise and experience to the review process. The group will include:
  - o At least one DD Council member and one member of the Council's Program Committee, whenever possible.
  - o At least one person with a disability and a family member, especially those whose lives might be affected by the particular type of project(s).
  - o Representatives of minority and culturally distinct populations.
  - o Subject matter experts (e.g., experts in employment, housing, or community services, depending on the type of project), including service providers, state agency representatives and at least one person with evaluation expertise, whenever possible.
  - o One or more RICC members and representatives of local service agencies for local projects.

> **"Grant reviewers** [surveyed] **believed that organizational mission, proposed consumer involvement, and proposed diversity outreach … are all-important criteria for … who should receive funding."**
> -- Recent report from the *Evaluation of DD Council Activities*.

It is important to remember that there will be reviewers who will **NOT**:

- o Understand professional jargon or the technical language of your particular field;
- o Recognize acronyms, especially those for local agencies in your area;
- o Already know about your organization's history and reputation.

On the other hand, there **WILL** be reviewers who:

- o Are sensitive to being labeled because of their disability;
- o Prefer the use of "People First" language; ("Person with a disability," not "Disabled person.")
- o Take exception to language that patronizes or talks down to people with disabilities and their family members.

3. Checklists

For assessing proposals developed in response to a Michigan Developmental Disabilities Council Request for Proposals (RFP)

The following tools are provided for your convenience, to help you cross-check your proposal, to assure that it includes all the needed elements, and, to some extent, to help you assess the completeness of your plans for elements like outreach, cultural competence and sustainability.

3.A. Checklist of General Requirements: Elements needed for ALL responses to DD Council RFPs

3.B. Checklist for Reviewing Health Care Coordination Models

3.C. Checklist for Reviewing Evaluation of Care Coordination Models

3.D. Sustainability Checklist: Indicators of Readiness and Ability to Promote Sustainable Systems Change

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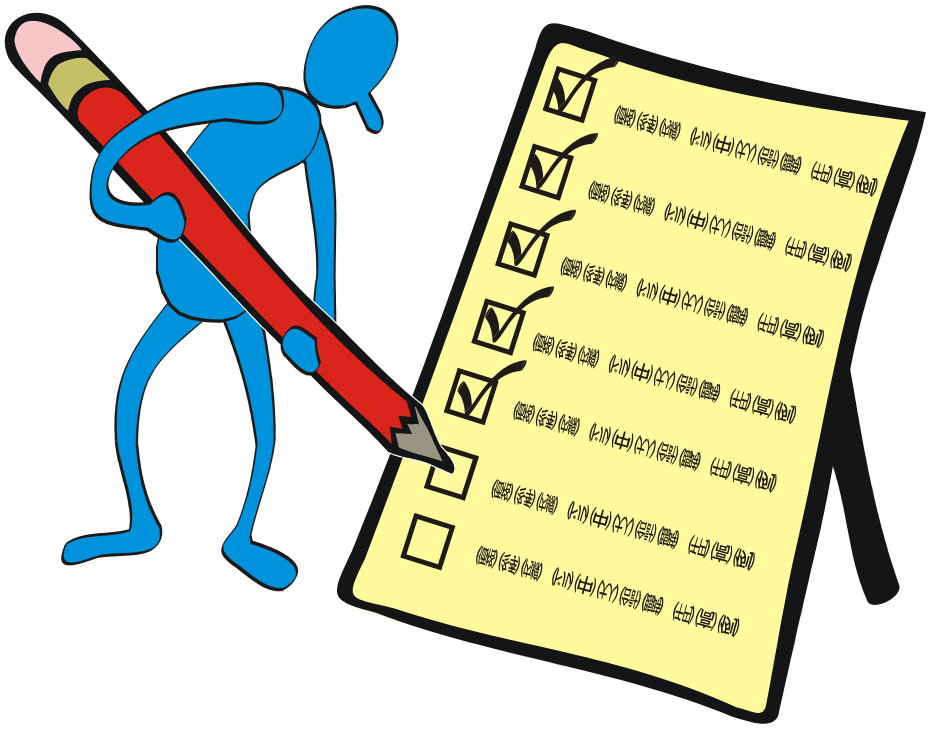
Checklists are provided for YOUR convenience.
Do not include them with proposals.



3.A. Checklist of Requirements for All RFPs

Proposal Cover Sheet is completed, including:

- ☐ Complete contact information (address, phone, fax, email);
- ☐ Authorizing signature, with the top copy in original colored (not black) ink;
- ☐ Budget figures at the bottom for the first year of the proposed project.

Summary of Assurances, including description of:

- ☐ How people with DD and family members, including minorities, participated in developing the proposal;
- ☐ How they will participate in carrying out and evaluating the project and where plans are in the proposed workplan;
- ☐ Minority outreach and of cultural sensitivity in development, execution and evaluation;
- ☐ How the proposed project will evaluate its activities and accomplishments, including where to find it in the proposal;
- ☐ Plans for assuring that project outcomes are sustained beyond the grant period;
- ☐ How information and products will be disseminated.

Narrative Summary, including summary information about:

- ☐ Problems to be addressed;
- ☐ Activities: What the proposed project would do;
- ☐ Organizational capacity of the applicant agency and other participating organizations;
- ☐ How the proposed activities will lead to the targeted outcomes specified in the RFP;
- ☐ Where and how data will be collected, analyzed, reported and used to improve the project
- ☐ What the proposed project will do to assure sustainability; and
- ☐ Dissemination summary for the Council's use in announcing awards.

Target groups: Description and **NUMBERS** of people the project expects to serve, train, educate, influence- may include:

- ☐ Number of people with DD by the level of supports needed;
- ☐ Number of people with DD by other relevant characteristics;
- ☐ Other target groups by their role for people with DD and by the characteristics that matter in the project's context.
- ☐ All target groups by race.

Outreach Strategies: Description of the proposed project's plans to assure diverse participation by:

- ☐ Members of minorities and culturally distinct populations;
- ☐ People with all categories of developmental disabilities;
- ☐ People who need all levels of support, with emphasis on those with high and very high support needs.
- ☐ **Workplan and Schedule** forms, including one table for each quarter of Year One of the project.

Budget Forms for Year 1 of the project, including:

- ☐ Program Budget Summary, and
- ☐ Program Budget-Cost Detail.
- ☐ **Review Criteria:** The completed proposal has been checked against them. (Sec. II of the RFP.)

3.B. Checklist for Reviewing Health Care Coordination Models

- ☐ The proposal has plans to demonstrate the model of care coordination described in *Supplemental Information and Tools.*
- ☐ The proposal has plans to use person centered planning to create and use an individual plan for each person receiving services that:
  - ☐ Promotes self-determination and choice for the person receiving services;
  - ☐ Uses a team that includes the person receiving services to create and monitor an individual health care plan and carry it out in accord with the wishes of the person receiving services;
  - ☐ Includes "non-covered" services in its development and monitoring; and
  - ☐ Focuses beyond specific health promotion to include the person's overall goals for his or her life.
- ☐ The project would include, as project partners, consumers, public and private agencies that serve people with developmental disabilities, health care systems, and advocacy organizations.
- ☐ The project would develop written agreements that describe the roles of each partner in carrying out the model.
- ☐ The proposal includes plans to use the key aspects of effective long-term supports and care coordination, such as a quality improvement structure, an effective system for collecting and analyzing data, and a core system component that develops community resources and linkages.
- ☐ The project will serve a diverse group of at least 50 adults with DD, of various ages and ethnicity, who need a wide array of health care and other supports and complex medical and long-term care services; and are at risk of high health care utilization.
- ☐ The project will assess the status of each consumer's healthcare over the three-year grant period; and monitor the impact of care coordination on costs and consumer health care outcomes;
- ☐ The proposal states specifically that the project will participate in the cross-project evaluation, including quarterly round-table meetings;
- ☐ The proposal states specifically that the project will provide routine feedback to, and communication with, the DD Council's Health Issues Work Group
- ☐ The applicant plans to develop a replication handbook, for communities interested in creating a health care coordination system.
- ☐ The proposal includes a list of initial partner organizations and their anticipated roles in the project, which includes an agency serving people with DD and a health care provider system.
- ☐ Letters of commitment include concrete specifics about the letter-writer's experience with the applicant's collaborative work, and what the writer commits to support for the proposed project.
- ☐ This project will achieve the Council's intended outcomes, including positive, concrete, measurable changes for people with developmental disabilities and their families.

3.C. Cross-Project Evaluation of Health Care Coordination Models

- ☐ The proposal has an evaluation design that includes:
  - ☐ Assistance to the projects in developing internal evaluation;
  - ☐ Setting outcome indicators and developing common data elements, to enable aggregation;
  - ☐ Formative feedback to projects, to improve model development and participant outcomes; and
  - ☐ Comparison of project designs and methods, and their relationships with outcomes and participant satisfaction.
- ☐ Includes assessment of each pilot's health care coordination model with all the required elements;
- ☐ Includes assessment of each pilot's results that considers all of the targeted outcomes;
- ☐ Includes plans to hold quarterly round-table meetings of the pilots' project directors;
- ☐ Includes plans for reports, including reports:
  - ☐ To the Council with data analysis and recommendations.
  - ☐ Suitable for dissemination, usable by the projects, other communities, and the Council.
- ☐ The description of experience and accomplishments demonstrates ability to do this evaluation.
- ☐ Includes examples of reports and other communication products that show ability to convey technical information to lay audiences.
- ☐ Letters of support include concrete specifics about the applicant's evaluation work and track record of producing clear, useful recommendations and other evaluation products.
- ☐ Includes evidence that the applicant has access to the skills and experience needed, including:
  - ☐ Capacity to collect, compile, analyze and present data in ways that are sensitive to the needs of people with disabilities;
  - ☐ Experience with producing clear, informative communication efforts targeted to a variety of expert and non-expert audiences.
- ☐ The applicant has experience with, understanding of, and commitment to, self-determination and community inclusion for people with DD and their families.
- ☐ The proposal states directly that people with disabilities, family members and minorities participated in developing the proposal and describes their meaningful contributions.

3.D. Sustainability Checklist:

Indicators of Readiness and Ability to Promote Sustainable Systems Change

Does the organization sponsoring the proposed project have:

1. Strong Organizational Commitment to Systems Change **as indicated by:**
   - **A.** A collective desire to be a champion team. ☐
   - **B.** A "*Yes I can*" attitude. ☐
   - **C.** Strong leadership commitment to the efforts needed for the proposed project to succeed. ☐
   - **D.** Leadership's willingness to take risks and support innovative programming. ☐
   - **E.** Organizational mission and focus compatible with the Council's intended outcomes for the project. ☐

2. **Consumer-Driven Focus as indicated by:**
   - **A.** Program flexibility that allows consumers' needs and preferences to direct service provision. ☐
   - **B.** Long-term organizational commitment to self-determination for people with disabilities. ☐
   - **C.** Significant use of consumer input in developing plans and in operating and evaluating programs. ☐

3. **Effective Use of External Resources as indicated by routinely:**
   - **A.** Making positive use of factors like state funding or shifts in the job market. ☐
   - **B.** Building on prior relationships with other organizations to implement system change projects. ☐

4. **Ability to Build on Existing Resources as indicated by:**
   - **A.** The organization and its staff have experience with innovative programming and systems change. ☐
   - **B.** A history of making creative use of available resources in the community. ☐

Do the planned activities of the proposed project include:

1. **Actively Spreading the Word about Project Successes as indicated by plans for promoting:**
   - **A.** Citizen, policymaker, and leader awareness of the project's successes. ☐
   - **B.** Stakeholder buy-in to systems change, service innovation and other targeted outcomes. ☐

2. **Commitment to Tenacity in Pursuit of Change and Success as indicated by plans for:**
   - **A.** Eliminating and/or circumventing barriers to the project's objectives. ☐
   - **B.** Evaluation that will provide ongoing information about their progress toward their goals. ☐

3. **Moving the Sponsoring Organization Towards Recognition as an Expert in Innovation by:**
   - **A.** Developing expertise over time via projects and activities that build on one another, promoting a growing sense of competence and recognition within the organization and in the community. ☐
   - **B.** Informing decision makers and community members of the organization's efforts and successes. ☐

Continued on next page . . .

Do the planned activities of the proposed project include:

4. Promoting new philosophies and practices in the community, indicated by plans for:

- **A.** Formal and informal education campaigns to foster change in the community. ☐
- **B.** Promoting change in the policies and practices of community agencies. ☐
- **C.** Targeting the project to motivated consumers who *want* to pursue changes in their lives. ☐
- **D.** Using a holistic approach, recognizing that the project addresses only one part of participants' lives, and integrating project efforts with other important services in the community. ☐
- **E.** Establishing the project as a resource rather than as an ongoing service provider, and providing training for the community service system on how to provide the innovative services. ☐

5. Creative Development of Long-Term Funding by plans for:

- **A.** Identifying alternate sources of funding. ☐
- **B.** Applying for foundation grants and seeking community dollars. ☐
- **C.** Redirecting organizational funds for flexibility and to facilitate long-term funding. ☐
- **D.** Embedding project efforts into another, already existing line-item service. ☐
- **E.** Collaborating with other community organizations in long-term project funding ☐

6. Incorporating a Strong Consumer-Driven Effort by plans for:

- **A.** Significant consumer involvement in planning and decision-making and in project operations. ☐
- **B.** Mobilizing consumers at a grassroots level to direct change. ☐
- **C.** Evaluation that engages consumers in assessing the project's progress, products and achievements, and in developing ways to use evaluation information to improve the project. ☐

7. Creating Effective Collaborative Relationships with key Stakeholders/Agencies by:

- **A.** Creating partnerships with needed stakeholders. ☐
- **B.** Outsourcing service delivery to others who can easily integrate and sustain long-term efforts. ☐
- **C.** Sharing resources and costs of service provision with other key community agencies. ☐
- **D.** Recognizing and respecting partners' roles in the process. ☐

8. Making it Easy for Consumers and Staff to Promote Sustainability by plans for:

- **A.** Recognizing and respecting partners' roles in the process ☐
- **B.** Taking time to foster shifts in community attitudes through formal and informal education. ☐
- **C.** Building the necessary support network by enhancing and building upon existing resources. ☐
- **D.** Actively spreading the word about project successes. ☐

4. Vendor Registration with the State of Michigan.

You need to be registered as a vendor with the State of Michigan

before you can:

- Receive payment from the State of Michigan.
- Do business with the State.

This applies to individuals, businesses, units of government, municipalities, schools, colleges and universities. Contractors and vendors can register to sell goods and services to the State.

The DD Council cannot issue a grant award to an organization unless it is registered.

Note: The registration Web site uses 128-bit encryption for your protection. The site is best viewed using **Microsoft Internet Explorer 5** or higher or **Netscape 4.78** or higher, and the browser must be set to use the U.S. (not the International) security encryption. Your browser needs to be enabled to accept session cookies, and the site recommends a Javascript capable browser with Javascript enabled.

If you can't get the Web site to work for you, use the email, telephone or fax information below to

The state provides several ways you can register:

- You can register on the Internet at http://www.cpexpress.state.mi.us/.
- Email your request to DMB-vendor@Michigan.gov, or
- Telephone to (888) 734-9749 [toll-free] or (517) 373-4111 [local in Lansing], or
- Fax to (517) 373-6458.

Registering ahead of time will speed up the grant process and reduce the delay between receiving an award letter and receiving grant funds.

5. Information Specific to Health Care Coordination

5.A. Essential Resources.

These resources contain essential information for developing your proposal.

5.A.1. A Model of Service and Supports Coordination in Michigan's Long-Term Care and the Community Mental Health Systems. (Michigan DD Council Concept Paper.) This paper is also available for download at www.michigan.gov\ddcouncil;

5.A.2. Consumer-Directed Health Care: How Well Does It Work? – Summary and Key Points. from the Report by the National Council on Disability

5.A.3. Glossary of Terms

5.B. Optional Resources.

A list of websites that contain extensive information about consumer-directed health care and health care for people with disabilities.

5.A. Essential Resources

5.A.1. A Model of Service and Supports Coordination in Michigan's Long-Term Care and the Community Mental Health Systems

Background

Michigan, similar to many states, has a fragmented and complex system of long-term care for persons with disabilities in the community mental health (CMH) and long-term care systems. Elders and people with disabilities who have needs for assistance, support, and health care often face a confusing array of systems and services often ending in poor outcomes such as unnecessary hospitalizations or a fast track to a nursing home, the least desirable from the individual's perspective and frequently the most costly option. As a recent report described:

> People with multiple chronic conditions typically receive health and home care services from different systems, often from multiple providers within each system. As a result, the health care delivery system for those with chronic conditions is complex and confusing; care is often fragmented, less effective than it might otherwise be, and more costly. Care for people with chronic conditions accounts for 77 percent of Medicaid spending for beneficiaries living in the community.1
>
> A Washington study found that the prevalence of [long-term conditions] was higher for persons with avoidable hospitalizations than for all persons with a hospital stay.1

Within the long-term care system in Michigan, there has been little action or reform in addressing the significant need for health care and supports coordination for those in the long-term care system. Despite the years of bi-partisan and public calls for change, little has been done to offer individuals a better, coordinated system.

As a recent paper issued by the MediCal Policy Institute and the Center for Health Care Strategies states:

> [The need for] Care coordination for people with disabilities goes beyond the medical models of case management and disease management. It is critical that care coordination not be … gatekeeping. It must address the medical and psychosocial needs of beneficiaries and focus on wellness and prevention (particularly of secondary conditions). Care coordinators manage plan-covered and non-covered services … and help consumers navigate complex networks of specialty, ancillary, and supportive services.

[1] Partnership for Solutions, *Coordinating Care*, John Hopkins University, National Academy for State Health policy. P. 1

Problem/Purpose/Target Population to Be Addressed By This Project

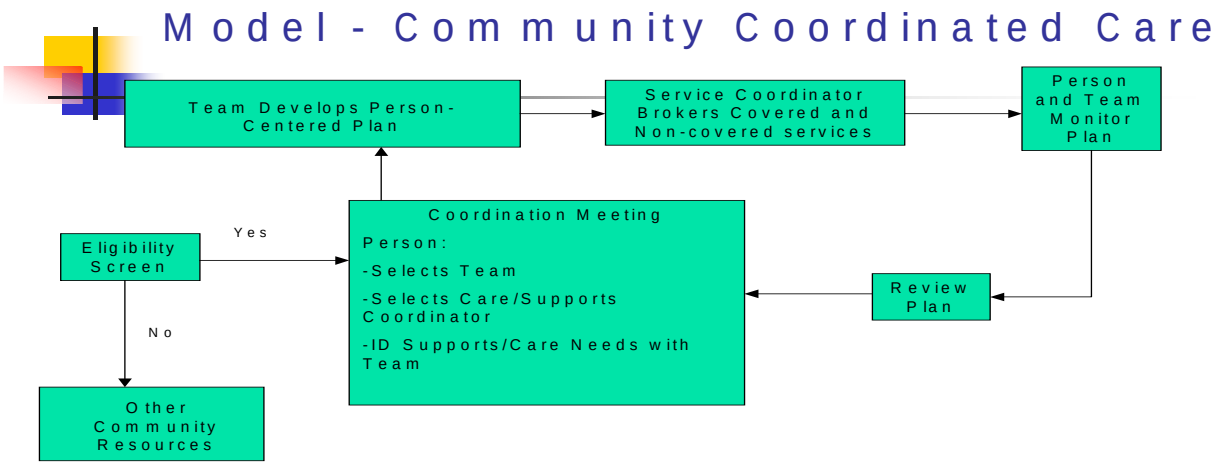
Over the past year, the Michigan Developmental Disabilities Council convened a Health Issues Work Group that has been reviewing this situation in Michigan. The Workgroup's mission is to increase the quality, availability and range of health care supports and services statewide. In this area, the Workgroup has identified three major areas of concern: basic access to health care for persons with disabilities, the quality of healthcare available if initial access is available and the disparity between health care coordination for persons with in the CMH System and for persons with disabilities who are outside the CMH System. The Workgroup believes that a consistent model of coordination within the long-term care and CMH systems could provide a needed solution to these problems.

The purpose is to implement the following model of care coordination that reflects shared decisions, improved access, quality of services and continuity of care across the life span for persons with disabilities.

The target population(s) for the project is a diverse group of persons with disabilities at a risk of high health care utilization. This would include persons with developmental disabilities both within and outside of the CMH system and individuals with disabilities with complex health care needs.

The Proposed Model of Coordination

Michigan's emphasis on person-centered and family-centered planning within the mental health, developmental disabilities, and children's with special health care needs system of managed care offers a unique opportunity to demonstrate a better coordinated and cost-effective system of long-term care. Such a system model would look something like this for an individual in either system of care:



The key aspects of effective long-term supports and care coordination in the long-term care systems and/or the CMH system include:

◊ The values of person-centered planning, self-determination and choice for the consumers

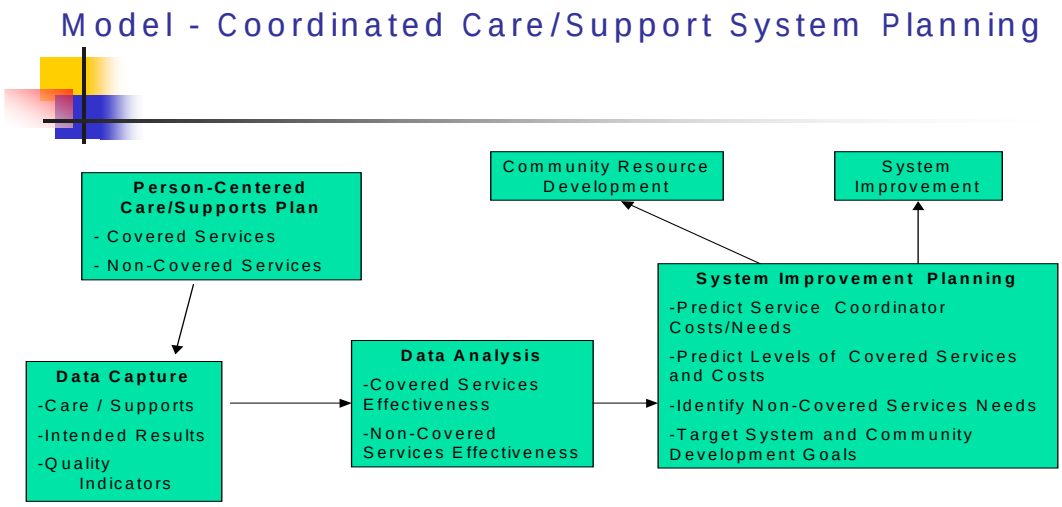
◊ The broad concept of team development and monitoring of an individual plan.

◊ The inclusion of "non-covered" services in the development and monitoring of a plan.

◊ The plan is focused on the person's goals for his/her life as well as specific health promotion.

[1] Id. P. 6.

Such a system model would look something like this for a care and supports organization:



From an organizational perspective the key aspects of effective long-term supports and care coordination include:

◊ A structure of quality improvement.

◊ A useful system of data collection and analysis, including cost.

◊ A component of community resource development and linkages.

The Activities of the Proposed Collaborative Project Funded by the Michigan Developmental Disabilities Council

It is proposed that the Developmental Disabilities Council engage in process that would fund 3-4 communities within in the State to pilot the proposed care coordination model described above to address the problems identified in the opening of this document. The pilot sites will be geographically distributed and represent both rural and urban settings. They will receive three-year grants to complete the following activities.

(1) Identify at least 50 persons with developmental disabilities and other long-term care support needs who are at risk of high health care utilization within their community and assess the status of their healthcare, including but not limited to: the presence of a primary health care provider, the availability and linkages to specialty care, their cost for care and their need for care coordination.

(2) Implement the above model of care coordination for at least 50 persons needing long-term care supports, including persons with developmental disabilities in their community. The "ideal project" would include a partnership between a local CMSHP and/or Area Agency on Aging, a health care system/clinic/ physician and a long-term care or supports provider to develop the proposed system of care coordination. The partnership should also include consumer representation in the planning and implementation of the model. However, any community that could demonstrate the capability to implement the model without one of the ideal partners would qualify for assistance. The proposed ideal partnership would allow the

projects to utilize the CMHSP to provider care coordination for persons within their system and the health systems/long-term care provider(s) would develop the same care coordination system within their systems.

(3) Monitor the impact of care coordination on costs and consumer health care outcomes including access to preventive care.

(4) Agree to participate in a study that compares this care coordination model with other models

Outcome Indicator	**Data Collection by Applicant**
Systemic Indicators: (1) Improve relationships between health systems, public systems, and long term supports/care providers	Formal and informal agreements between the parties, process evaluation measures such as minutes of meetings, number of meetings, type of meetings, etc.
Community Indicators: (1) Increased access to preventive healthcare (2) Increase knowledge of health care needs of persons with disabilities	Collect health utilization data (see below); Self report of individuals in the partnership
Individual Indicators (1) Shift in utilization of health care resources to more primary care and preventive care (2) Quality of Life Indicators (3) Improve Health Status	Health utilization data on participants in the prior year or in Year 1 before care coordination begins, and again in Year 2 and 3 Completion of standardized Quality of Life instrument in Year 1 and again in Year 3 Collection of up to 10 health status indicators in Year 1, 2, and 3

Resources:

This project will provide three years of funding with a 25% decrease each year. Projects need to include information on sustainability of the model for each year and sustainability in year four when DD Council funds are no longer available.

The proposed funding amounts are: $100,000 for Year 1; $75,000 for Year 2; and $50,000 for Year 3. Funding could be used to hire care coordinators, a project director and project operation costs. Each applicant should also identify at least a 10% cash or in-kind match for the project.

The DD Council should also allocate up to $50,000 per year for an evaluation of this project.

Product(s):

This project will produce at least two replicable, operational models of care coordination.

Applicants will provide a summative report that identifies the structure of model, who it is effective for and steps for replication. In addition, the projects will identify sustainability strategies in the project communities and for future replication.

Conclusion

Demonstrating the operation of this model of care and supports coordination in the long-term care system, with quantifiable outcomes and cost-effectiveness, would assist Michigan and other states move ahead with reform of a complex and flawed existing system.

As the CEO of AXIS Healthcare, a long-term care plan for adults with chronic illnesses and disabilities in Minnesota, notes, "if we avert just one hospitalization, care coordination is paid for and the member has improved quality of life."[1]

Background Resources:

Minnesota – AXIS Healthcare

National Council for Community Behavioral Healthcare Organization Background Paper on Integrated Health Care, May 2003

Children's Special Health Care – Care Coordination Model

WCHO Care Coordination Model

[1] Id.

5.A.2. Consumer-Directed Health Care: How Well Does It Work? Report by the National Council on Disability

October 26, 2004

A systematic review of literature on consumer-directed health care for persons with disabilities was conducted to evaluate the evidence base of this topic and to answer several key questions: what current models for consumer-direction exist and what do these models tell us about preferences, outcomes, and cost-effectiveness involved with consumer-directed health care for persons with disabilities? In addition, the report assesses the extent and types of knowledge about federal and state consumer-directed health care policies, programs, and practices and offers recommendations oriented to policy and research.

Upon review of this report, parallels between health care for persons with disabilities and older adults are evident. Similarities include government policies, laws, programs, and regulations that play a role in the care of both persons with disabilities and older adults (Olmsted Decision, Medicaid, HCBS Waiver), predilection towards care in institutional settings, health care environments in which the ability of consumers to direct their own care is nil, but also reforms towards creating innovative ways to change these realities. Research on consumer-directed care is limited, but enough exists to support innovative programs and policies that offer alternatives to the status quo.

Much can be drawn from this report and applied to consumer-directed care for older adults. The aging network can learn from research studies like those mentioned in the report and use them as guides to conduct research explicitly with older adults and to inform policy makers and stakeholders in aging policy and programs. In addition, the same recommendations with regards to consumer-direction made in the report for policy makers and researchers have explicit relevance for the aging network. The research presented in this report is limited in its scope and generalizability. However, it encourages a dialogue about consumer-directed care for older adults, one that includes such questions as: in what settings is consumer-direction most optimal, what are the policy and/or programmatic barriers to implementation, how can consumer-directed care services best be actualized for older adults?

Key points from the report with implications for aging are outlined below. A more complete version can be found at:

http://www.ncd.gov/newsroom/publications/2004/consumerdirected.htm#conclusions

Key Points

- Services should meet needs of broad range of consumers, be individualized, and offer consumer as much flexibility and choice related to their care as possible
- Studies and interviews show that the best outcomes happen when consumers make their own choices among service options
- Policy/program recommendation: address issues around recruitment, training, shortage of personnel
- Report promotes a shift away from diagnosis-focused approach with limited range of service options to lifespan approach in which services meet individual needs
- Disability community is about expanding opportunities for independence, quality of life, social integration, maximizing autonomy (the same can be said of aging)

- 'Medical model' views disability as abnormal and persons with disabilities as abnormal people who need to be fixed through medical interventions
- Report encourages initiatives that involve consumers in research and program design/evaluation and that ensure that the consumer's point of view is included in outcome measures (community-based participatory research)
- Results of studies of the preferences for consumer-directed health care include (all seven studies used included older adults):
  - Substantial number of people over age 65 expressed preference for consumer-directed care
  - No significant association found between gender and preference for consumer direction
  - Preferences were found to vary by race/ethnicity
  - Other factors associated with preference for consumer-directed services: education level, health status, current service use, availability of family and other informal caregivers, prior experience with hiring, paying, managing, and supervising caregivers and willingness to do these activities
- Studies of outcomes of consumer direction show greater consumer satisfaction with services, perceived empowerment, quality of life as compared with agency-directed services (definitive research conclusions are difficult due to non-uniformity in research procedures and questions); no evidence that consumer direction compromises safety
- Conroy et al. (2002) conducted a study of Robert Wood Johnson Foundation-funded Self Determination project in Michigan. The study showed that people with developmental disabilities experienced greater empowerment and control during the project; these individuals were involved in hiring, firing, and choosing agency personnel and choice of case manager; study used an instrument called the Decision Control Inventory
- Studies show that Waiver Programs cost less per participant than nursing home care; HCBS has positive impact on quality of life and satisfaction; impact HCBS had on preventing nursing home admissions was negligible unless Waiver services were highly targeted to those most likely to enter a nursing home
- Factors that facilitate implementation of consumer-directed care:
  - Federal initiatives: Money follows the person, Real Choice Systems Change and Medicaid Infrastructure Grants
  - Foundation support for pilot projects, multistate demonstration projects, start-up costs for new initiatives, program evaluation
  - Advocacy and policy leadership
  - Research and evaluation around safety, satisfaction, quality of life
  - Reliable and fully accessible support services like meal preparation and delivery, transportation, and housing makes living in the community and consumer-directed care feasible
  - Understanding of service options, education, and skills training among consumers of consumer-directed care services is crucial for the success of this model
- Inconsistency exists in which terms are used and how they are defined with relation to consumer-directed care.

5.B. Optional Information

These websites contain extensive information about consumer-directed health care, and health care for people with disabilities.

1) Full Report of the National Council on Disability – web site.
   Consumer-Directed Health Care: How Well Does It Work?
   www.ncd.gov/newsroom/publications/2004/consumerdirected.htm

   We recommend that you at least read the Executive Summary, so that you can see what information the report contains.
   http://www.ncd.gov/newsroom/publications/2004/consumerdirected.htm#executive

2) The National Council for Community Behavioral Healthcare Organizations' Background Paper on Integrated Health Care, at
   http://www.nccbh.org/SERVICE/CONSULT/consult-pdf/PrimaryCareDiscPaper.pdf

3) A descriptive press release about the Washtenaw Community Health Organization's Care Coordination Model, at http://www.med.umich.edu/opm/newspage/2004/wcho.htm

4) Information about Minnesota's AXIS Healthcare, at
   http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_006272.hcsp.

5) It takes more than ramps to solve the crisis of healthcare for people with disabilities.
   Rehabilitation Institute of Chicago, 345 E Superior St, Chicago, IL 60611
   http://www.ric.org/community/RIC_whitepaperfinal82704.pdf

Do not print these publications without looking at them first – some are 60-90 pages long.

Glossary of Terms

Consumer-Directed Care (from the Report by the National Council on Disability) The terms "consumer-directed care" and "consumer-oriented care" have different meanings. The term "consumer-directed care" has its roots in the independent living movement and is most commonly used in reference to home- and community-based long-term care and support services. Consumer direction of services grows out of a philosophical orientation that emphasizes the ability of people with disabilities to assess their own needs and make choices about what services would best meet those needs. It also reflects a view that consumers can and should have options to choose the personnel or provider entities that deliver their services, manage the delivery of services, and monitor the quality of services. Consumer-directed care is applicable across the spectrum of disability, although the language used to capture the concept varies among disability groups. For purposes of this project, consumer-directed care is considered to apply to a system or strategy with the characteristics described above in relation to any disability and for any age group. It is important to note that "consumer-directed," as used in this report, should not be confused with the current insurance industry use of the terms "consumer-directed" and "consumer-driven" to refer to private health insurance characterized by high deductibles and low premiums.

Consumer-Oriented Care (from the Report by the National Council on Disability). Consumer-oriented care has a broader definition than consumer-directed care. Decisions in the health care world are typically driven by a combination of clinical expertise and business concerns. The term "consumer-oriented care" applies to reforms and strategies within health care delivery systems that are "directed" by professionals or by provider/consumer partnerships but seek to ensure that decision making is responsive to the needs and concerns of people with disabilities. Consumer-oriented practices include strategies to expand insurance coverage or benefits for people with disabilities; to promote health and well-being through primary and preventive services; to provide integrated and interdisciplinary care; and to promote the delivery of care in the least restrictive setting (Ireys et al., 2002).

In practice, the line between consumer-directed and consumer-oriented care is not precise. Some systems lie somewhere between the two and some are designed to incorporate elements of both. It is less important to make a precise distinction between the two than to recognize differences as research is carried out so that real differences among models of care are identified and analyzed as the basis for deeper understanding.

Formative evaluation is a method of assessing the worth of a program while program activities are forming or happening. Formative evaluation focuses on the *process*. It provides information to enable adjustments or development of new strategies to improve the program. It can be used, for example, to test the effectiveness of program approaches, to improve measurement tools, and to collect continuous feedback from participants in a program in order to revise the program.

Summative evaluation, on the other hand, is a method of assessing the worth of a program at the end of the program activities. The focus is on the *outcome.* Data collected may be used to determine the impact of the project on the lives of consumers, report consumer satisfaction with the project and its results, and to compare the results of different approaches or models. [1]

[1] http://www.ed.gov/pubs/EdTechGuide/whatseval.html

Health Care Provider. A person, agency or organization that has the capacity to deliver primary and specialty health care with a focus on person-centered outcomes. Services may include, but are not limited to, in-patient hospital, out-patient services, occupation/physical therapy, managed care organizations, home help or health services, substance abuse, emotional counseling, etc.

Non-Covered Services. Non-covered services include any service(s) important to the health or well-being of a person that may not be provided by any one agency or organization that serves people with disabilities (e.g. Community Mental Health, Family Independence Agency/Department of Human Services, schools, hospitals, health clinics, etc.). Examples of the range of services and supports that may need coordination include, but are not limited to, physical and mental health, housing, education, employment, Social Security benefits and financial assistance, transportation, family support, etc.

Person-Centered Planning (PCP). Person centered planning is a highly individualized process designed to respond to the expressed needs and desires of the individual. Various approaches may be used, but person centered planning is distinguished by the fact the individual directs the planning process with a focus on what he or she wants and needs. Development of the plan of service is based upon the expressed needs and desires of the indiivdual. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate. For the meeting, the individual chooses dreams, goals, desires and any topics he or she wants to discuss, and topics that will not be discussed; who to invite; where and when the meeting is held; who facilitates; and who records. The process is intended to develop the appropriate mix of paid and non-paid services and supports to help the individual realize and achieve his or her personally-defined goals and aspirations[1]

Self-Determination. Self-determination incorporates a set of concepts and values that emphasize participation and the achievement of personal control for individuals served. These concepts and values stem from a core belief that people who need supports and services must have freedom not only to define the life they seek, but to be supported to direct the assistance they require in pursuit of that life. Persons who need supports and services must have access to meaningful options from which to make choices, and be supported to control the course of their lives.[2]

Service Agencies. Relevant service agencies include Area Agencies on Aging (AAA), Community Mental Health (CMH), Family Independence Agency/Department of Human Services (FIA, now DHS), Local and intermediate school districts, Michigan Rehabilitation Services (MRS), and local or county public health departments.

[1] Person Centered Planning Practice Guideline: http://www.michigan.gov/documents/PCPgud02_83966_7.pdf
[2] Self-Determination Practice Guideline: http://www.michigan.gov/mdch/0,1607,7-132-2941_4868---,00.html